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Sociodemographic Characteristics of Aotearoa New Zealand Oral Health Students: Do Student Cohorts Reflect the Society They Will Serve?

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ABSTRACT

This study evaluated sociodemographic characteristics of students enrolled in dentistry, oral health and dental technology in Aotearoa New Zealand (NZ) between 2016 and 2020. Sociodemographic data were obtained from central student record systems and NZ population data from the 2018 Census. Age, gender and citizenship status were analysed for the whole cohort, whilst other categories were analysed for NZ citizens and permanent residents only. Descriptive statistics were presented as raw counts or rates per 100,000 of the population. Most NZ students were educated in the public system. For dentistry and dental technology, a third of the cohort were international students, contrasting with only 4% of oral health students. Most NZ-educated students attended schools serving socioeconomically privileged communities. For all programmes, most students came from urban areas and there were more female than male students enrolled. Māori and Pacific students represented 9.3% and 5.4% of enrolments, despite representing 20% and 9% of the NZ population. Māori and Pacific peoples and those from rural and low socioeconomic areas were underrepresented, despite efforts to address such inequities. Admission policies in NZ universities need to ensure that Māori and Pacific peoples and those from rural and low socioeconomic areas are considered from a social justice and equity positioning.

1 | Introduction

Oral health professionals (dentists, oral health therapists and dental technicians) play an important role in providing positive oral health outcomes, which contribute to society's overall health and wellbeing. For health services to be more effective in enabling improved health outcomes, the health workforce (including the oral health workforce) must reflect the sociodemographic characteristics of the population it seeks to serve (Crampton et al. 2018; Crampton et al. 2023). This can only be achieved if the sociodemographic characteristics of students recruited into oral health programmes also reflect the composition of society (Mariño et al. 2006; Booth et al. 2022). This is because the sociodemographic characteristics of health professional students influence their future career choices

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regarding place of practice and populations served (Crampton et al. 2018).

The history of oral health education in Aotearoa New Zealand (NZ) dates back to 1907, when NZ's only dental school was established at the University of Otago in Dunedin, South Island (Cooper et al. 2022). In more recent years, dental specialists, dentists and dental technicians continue to undertake their study at Otago, whilst oral health therapists (previously registered as dental therapists and dental hygienists until 2017) can study either at the University of Otago or the Auckland University of Technology (AUT) located in Auckland in NZ's North Island. AUT established its Bachelor of Health Science (Oral Health) degree in 2006, and the University of Otago followed with its Bachelor of Oral Health (BOH) degree in 2007 (Coates et al. 2009). These are the only two universities currently offering qualifications in the oral health professions in NZ.

Despite considerable progress in ethnic and socioeconomic representation, NZ health professional courses, including those for oral health professionals, still experience underrepresentation of students identifying as Māori (Indigenous peoples of NZ) and Pacific peoples (a heterogeneous composite of Pacific ethnic groups living in NZ), students from regional, rural and refugee backgrounds, and students from schools serving low socioeconomic communities (Crampton et al. 2018; Crampton et al. 2023). It is well documented that Māori and Pacific people, and those from areas of higher socioeconomic deprivation and rural communities, disproportionately experience higher oral health needs and poorer outcomes (Ministry of Health 2009). To ensure that professional programmes produce graduates equipped to meet the oral health needs of NZ's society, in 2012 the University of Otago adopted a policy to ensure a more diverse student intake that reflected the country's ethnic and socioeconomic composition (Crampton et al. 2012; Fernando 2024). Following this policy, entry criteria for the BDS programme for Māori and Pacific applicants include verification of ethnic affiliation and meeting a grade threshold in the first year of university study. The sociodemographic characteristics of students in University of Otago health professional programmes for the years 1994–2023, including oral health programmes, have been published elsewhere (Crampton et al. 2018; Crampton et al. 2023; Sise et al. 2024).

This study, a subset of a larger cross-sectional study (Crampton et al. 2023), aimed to evaluate the sociodemographic characteristics of students accepted in the first year of study in the oral health professions (dentistry, oral health therapy and dental technology) in NZ between 2016 and 2020 (inclusive) and to assess whether these student cohorts mirror NZ's broad society.

2 | Methods

A detailed overview of the methods and data sources used in the wider series of analyses that this study is a part of is provided in Crampton et al. (2023). This section describes the materials and methods relevant to the current study focussed on oral health students.

2.1 | Position Statement

As outlined in Crampton et al. (2023), it is essential to contextualise studies looking at the sociodemographic characteristics of health professional students within NZ's colonial history. The authors acknowledge the Indigenous rights of Māori and that these rights have been (and continue to be) systematically breached. In addition to "rights-based" arguments for appropriate inclusion within health professional training courses in NZ, Māori and other marginalised groups within NZ such as Pacific peoples and people with regional, rural and/or lower socioeconomic backgrounds also have "needs-based" arguments that require social justice interventions to achieve equity within health professional training opportunities and outcomes (Curtis and Reid 2013).

Senior Māori and Pacific researchers played a critical role in contributing to the larger study design, data analysis and interpretation of data (Crampton et al. 2023). This is to ensure that the research is safe and takes a strengths-based approach in order that any recommendations that aim to address inequity within the health workforce and improve health outcomes will do so in a manner that is positive for Māori and Pacific peoples.

2.2 | Oral Health Professional Programmes and Student Eligibility

This study was approved by the University of Otago Human Ethics Committee (reference: 20/075). All students (domestic and international) accepted into Year 2 of the Bachelor of Dental Surgery (BDS) or Year 1 of the Otago Bachelor of Oral Health (BOH) or Year 1 of the AUT Bachelor of Health Science (Oral Health) or the Bachelor of Dental Technology (BDentTech) during 2016–2020 were eligible to be included in the study.

At the University of Otago, there are three pathways to admission to study BDS in NZ; after a foundational Health Science First Year (HSFY) course, following a previous bachelor's degree or in an alternative entry pathway where other relevant study is acceptable to the admissions committee. Selection into BOH and BDentTech at the University of Otago or Bachelor of Health Science (Oral Health) at AUT occurs through several pathways, including directly from secondary school study, after 1 or 2 or more years of university study, after a previous bachelor's degree or through an alternative entry pathway. For the purposes of this study, data from the two NZ oral health therapy education programmes have been combined.

For admission to the BDS programme, places were allocated between the HSFY, graduate and alternative categories. All applicants in these categories presented an Undergraduate Medical Admissions Test (UMAT) result obtained in the year of application; however, the University of Otago changed from UMAT to the University Clinical Aptitude Test (UCAT) for Australia and NZ in 2019. Applicants who met the UMAT/UCAT threshold score were invited to a dental admissions interview. Applicants who achieved a threshold level interview score progressed to selection for the BDS programme based on their average mark in the HSFY papers or GPA for those in the graduate category. For those applying in the alternative category, selection was based on academic merit and interview. Admission to the BOH and the BDentTech programmes at the University of Otago required academic records, curriculum vitae and statement of interest. Suitable candidates were ranked, with equal weighting between academic strength and personal characteristics (from the statement of interest and curriculum vitae). The final selection was based on ranking and the number of places available to the programmes. In the

current selection criteria such as with the introduction of Te Kauae Parāoa policy at the University of Otago in 2023, affirmative action policies are applied for Māori, Pacific, rural, low socioeconomic background and refugee background students. Admission to the Bachelor of Health Science (Oral Health) degree at AUT required submission of academic records only. Prospective students were then ranked based on the highest level of academic achievement and/or evidence of accomplishments in the relevant field, and final selection was based on ranking and number of places available.

2.3 | Data Sources and Variable Analyses

Student data were extracted from the University of Otago and AUT central student records systems. NZ population data (focused on 18–29 years) were obtained from the 2018 Census (Statistics New Zealand 2018).

Data on age, gender (male/female), citizenship status (domestic: NZ citizens and permanent residents, Tokelau/Niue/Cook Island citizens, Australian citizens and international), ethnicity (see below), rural classification (based on students home addresses and following two rural/urban classifications; the Stats NZ Urban accessibility classification, the purpose of which was to classify rural areas and small urban areas according to their proximity, or degree of remoteness, to larger urban areas (Statistics New Zealand 2020); and the Geographic Classification for Health (Whitehead et al. 2022) that had the following five classifications: urban: the six main centres in NZ [U1] and provincial cities [U2]; rural: R1, R2 and R3 based on distance to urban centres and relative population sizes in the area), socioeconomic deprivation (measured using NZDep2018) and school type and socioeconomic scores (whether state [the majority of schools in NZ; government-owned and fully state-funded], state-integrated [mostly schools that started as private or religious schools and have become part of the state system], private [nonstate schools that must meet certain standards to be registered; privately funded], correspondence [state-funded distance education school that offers programmes that are mostly delivered online] or homeschooling [parents educate their child at home] and a Ministry of Education school rating scale of decile 1–10 [decile 1 schools are the 10% of schools with the highest proportion of students from low socioeconomic communities, and decile 10 schools are the 10% of schools with the lowest proportion of these students]) were analysed for the three student cohorts (BDS, Oral Health Therapy [OHT] and BDentTech). Whilst age, gender and citizenship status were analysed for the whole cohort, the remaining categories were analysed for NZ citizens and permanent residents only (i.e. domestic students).

2.4 | Ethnicity Classification/Definitions

When students enrol at a tertiary institution in NZ, they can nominate up to three ethnicities they identify with; these ethnicities are self-declared. For this study, ethnicity was classified using the following:

1. Six level 1 groupings (Ministry of Health 2017): Māori, Pacific, Asian, European, MELAA (Middle Eastern, Latin American or African) and Other; classified according to the prioritised output method (see below).
2. Seventeen level 2 groupings (Ministry of Health 2017): classified according to the total response method.

With prioritised output, Māori who identify only as Māori, or as Māori plus one or more additional ethnicities, are categorised as Māori; Pacific peoples who identify solely as a Pacific ethnicity, or Pacific plus one or more additional ethnicities other than Māori, are categorised as Pacific and likewise for Asian people; the NZ European category includes NZ European, but not Māori, Pacific or Asian (Ministry of Health 2017). The "Asian" category, as used in the NZ health sector, includes students from East, South and Southeast Asia but excludes people from the Middle East and Central Asia. This category has acknowledged shortcomings because of the ethnic diversity within the category. In the level 2 groupings, the total response classification is used, where row percentages sum to more than 100% because each student could nominate more than one ethnic group affiliation.

2.5 | Statistical Analyses

Descriptive statistics are presented as raw counts or as rates per 100,000 in the population (using data from the 2018 Census); 95% confidence intervals are provided for the rates. For trends over time, score tests for trend of odds were obtained using Stata 18 and $p < 0.05$ was considered statistically significant.

3 | Results

3.1 | Overall Enrolment, Age and Gender Distribution

Over the years of 2016–2020, 472 students were enrolled in BDS (domestic and international). The majority of BDS students ($n = 278$, 58.9%) were NZ citizens with a further 8.9% ($n = 42$) identifying as NZ permanent residents. Just under one-third ($n = 144$, 30.5%) were international students and 1.7% were Australian citizens ($n = 8$). Almost half of students were aged 20–24 years (49.6%, $n = 234$). Overall, there were more female BDS students enrolled than males (62.5%, $n = 295$ vs. 37.5%, $n = 177$; Figure 1a). There were no significant changes to the proportion of female students over the period reviewed ($p = 0.676$).

A total of 504 students were enrolled to study OHT either at the University of Otago (47%, $n = 236$) or AUT (53%, $n = 268$) (domestic and international). Over two-thirds of OHT students ($n = 366$, 72.6%) were NZ citizens, and 22.2% ($n = 112$) were permanent residents. Only 4.2% ($n = 21$) of OHT students were international citizens and 1% ($n = 5$) were from Australia. Most students were aged 18–19 years (40.1%, $n = 202$) (Figure 1b). Most students enrolled to study OHT were female (90.9%, $n = 458$ vs. 9.1%, $n = 46$ males). There were no significant changes to the proportion of female students over the period reviewed ($p = 0.345$).

Over the same period, 83 students were enrolled to study BDentTech (domestic and international). Of these, 51.8% ($n = 43$) were NZ citizens or NZ permanent residents ($n = 16$, 19.3%). The remainder ($n = 24$, 28.9%) were international students. Most students were aged 20–24 years (47.0%, $n = 39$) (Figure 1c). Similar to BDS and OHT, there were more female than male students enrolled (75.9%, $n = 63$ vs. 24.1%, $n = 20$), and similar to the other

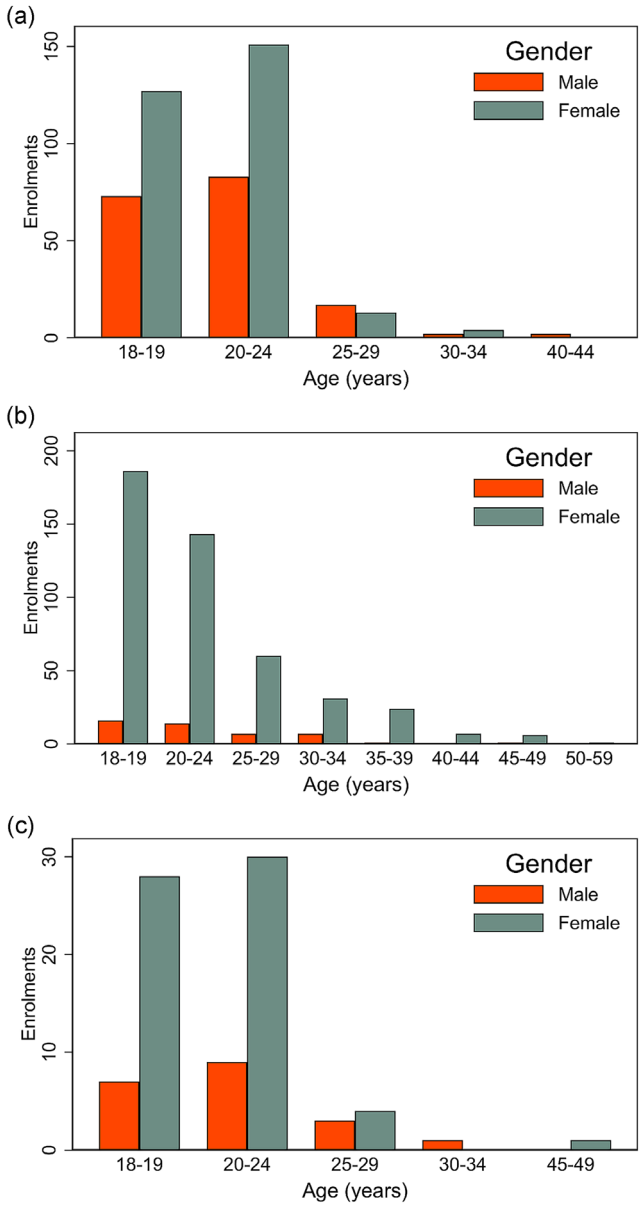

FIGURE 1 | Enrolments by gender and age group (domestic and international students; 2016–2020 inclusive). (a) Bachelor of Dental Surgery (Otago). (b) Bachelor of Oral Health (Otago) and Bachelor of Health Science (Oral Health) (AUT). (c) Bachelor of Dental Technology (Otago).

oral health programmes, the proportion of female students did not change significantly over the period reviewed ($p = 0.822$).

3.2 | High School Characteristics

Analysis of high school characteristics were performed for NZ citizens or permanent residents only (domestic students). Most BDS students attended state or state integrated high schools ($n = 205$, 62.5%, and $n = 49$, 14.9% respectively). Students attending either private ($n = 38$, 11.6%) or overseas schools ($n = 32$, 9.8%) represented less than a quarter of enrolled BDS students.

Over two-thirds of OHT students also attended state or state-integrated schools ($n = 325$, 67.3%, and $n = 57$, 11.8%, respectively). Students attending either overseas schools ($n = 36$, 7.5%) or private schools ($n = 13$, 2.7%) represented only about one-tenth of OHT students.

State school attendance was lowest amongst BDentTech students ($n = 32$, 54.2%). This was followed by overseas school attendance ($n = 11$, 18.6%), private ($n = 10$, 11.6%) or state-integrated ($n = 6$, 10.2%) schools.

3.3 | Enrolment Rates per Ethnic Group, Socioeconomic Deprivation and Urban Distribution

Analysis of enrolment rates per ethnic group, socioeconomic deprivation and urban distribution was performed for NZ citizens or permanent residents only (domestic students). In all oral health programmes reviewed, enrolment rates for Pacific students were lower compared to other ethnic groups, notably Asian and Middle Eastern (Figure 2). For BDS and OHT students, enrolment rates by ethnic group and socioeconomic deprivation showed a near log-linear negative relationship with increasing small area socioeconomic deprivation (Figure 3). This trend was not as evident for BDentTech enrolments (Figure 3).

For all programmes, most students came from urban areas with lower numbers of rural students. The rates of BDS enrolment for urban and rural areas were similar, although slightly lower for the R2/3 category, which comprises the most remote and isolated rural communities. The rates of enrolment were also lower for students from low and remote urban accessibility areas (Figure 4). Enrolment rates for OHT students were similar in urban (U2) and rural areas (R1–3), but higher for the urban (U1) category (Figure 4). The rates of enrolment were also higher for students from high and medium urban accessibility areas. In the BDentTech, the rate of enrolment was much higher for urban compared with rural areas. The R1 category was noticeably lower than other categories, and the rates of enrolment were also noticeably lower for urban students from medium, low and remote accessibility areas (Figure 4).

When considering the enrolments by geographical area and ethnicity, BDS enrolments for Māori and Pacific students were lower than the overall enrolment rate in urban settings, and in rural areas, enrolment of Māori students was lower than the overall enrolment rate (Figure 5). For OHT, Māori student enrolments were lower than the overall enrolment rate in urban settings, and for the rural settings, the enrolment rate for both Māori and Pacific students was lower than the overall enrolment rate (Figure 5).

4 | Discussion

This study examined the sociodemographic characteristics of students accepted in the first year of study in the oral health professional programmes in NZ between 2016 and 2020 (inclusive) to determine whether the student body reflects the characteristics of NZ's diverse society. Our findings revealed that most oral health students in NZ were educated in the public system, with lower numbers educated overseas or in private schools. For BDS and BDentTech students, a third of the cohort were international students, whilst only 4% of OHT students came from overseas. However, amongst oral health programme students who were educated in the NZ public education system, most attended higher decile schools (schools serving more socioeconomically privileged

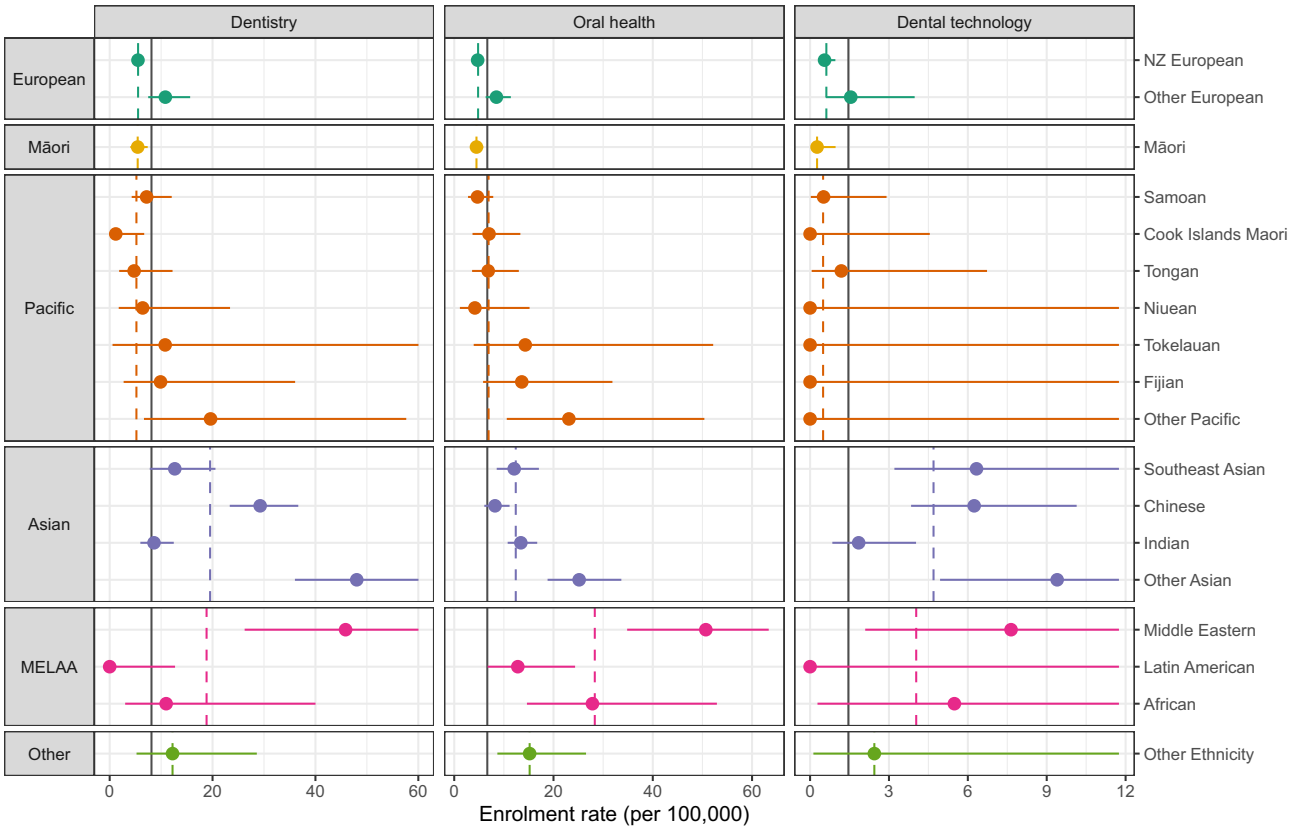

FIGURE 2 | Enrolment rates by ethnic groups (NZ citizens or permanent residents; 2016–2020 inclusive). Bachelor of Dental Surgery (Otago), Bachelor of Oral Health (Otago) and Bachelor of Health Science (Oral Health) (AUT) and Bachelor of Dental Technology (Otago). *Ethnicity: total response. Vertical grey line indicates overall enrolment rate, dashed line indicates enrolment rate for level 1 ethnic group and dots (lines) represent enrolment rate (95% CI) for level 2 ethnic group. MELAA = Middle Eastern, Latin American or African.

communities). For the oral health programmes reviewed, most students came from urban areas.

Māori represent almost 20% of the population of NZ (Statistics New Zealand 2023), but only 9.3% of oral health programme enrolments (8.9% for BDS, 2.4% for BDentTech, and 10.9% for OHT). This underrepresentation is also the case for Pacific students, who represent 9% of the NZ population but only 5.4% of oral health programme enrolments (4.2% for BDS, 3.6% for BDentTech and 6.9% for OHT). These findings of underrepresentation are consistent with other health professional programmes and are likely to reflect multiple, compounding issues including a failure of the primary and secondary education system within NZ to achieve equitable outcomes for Māori and Pacific students (including differential access to and performance within prerequisite subjects for oral health) (Crampton et al. 2018; Crampton et al. 2023). Additional barriers to tertiary education enrolment include an educational system that reflects predominantly British colonial norms and therefore does not adequately reflect Māori or Pacific cultural values or lived socioeconomic realities. In the United States, a 2020 study reported that only 12% of dentists self-identified as being Black, Latinx or American Indian, which does not reflect the demographic composition of the United States and reinforces systemic biases to sustainable dental school recruitment (Fleming et al. 2022). The chronic underrepresentation of ethnic minorities was also seen as a factor for health disparities amongst underserved communities. In the United States, this has been addressed with several pathway/pipeline programmes to increase the numbers of ethnic minorities in the dental workforce (Hewlett et al. 2022).

From the findings of this study, more needs to be done to recruit Māori and Pacific students into the oral health professional programmes. This is expected to contribute to improving oral health outcomes for all but notably for Māori and Pacific peoples' communities, where oral health needs are significantly higher when compared to the majority of the NZ population (Jamieson et al. 2016; Lacey et al. 2021; Boyd et al. 2022). The success of other NZ programmes such as Vision 20:20 at the University of Auckland that includes Māori specific recruitment into secondary schools, bridging/foundation education pathways for Māori and Pacific students to enter tertiary health study, an equity-admissions process and a comprehensive programme of student support once enrolled via the Māori and Pacific Admission Scheme (MAPAS), should be looked to as an exemplar for oral health programmes to follow (Curtis and Reid 2013; Curtis et al. 2017; Wikaire et al. 2017). Whilst this success has been most prominent for pathways into medicine, oral health-specific interventions may be helpful. The University of Otago has similar programmes that have resulted in increased recruitment of Māori and Pacific students into health professional programmes, particularly medicine (Crampton et al. 2012, 2018). Admission policies at both universities involved in this study have continued to evolve since the time of this study, including the introduction of Te Kauae Parāoa policy at the University of Otago in 2023. This policy promotes and facilitates equity in admission to the health

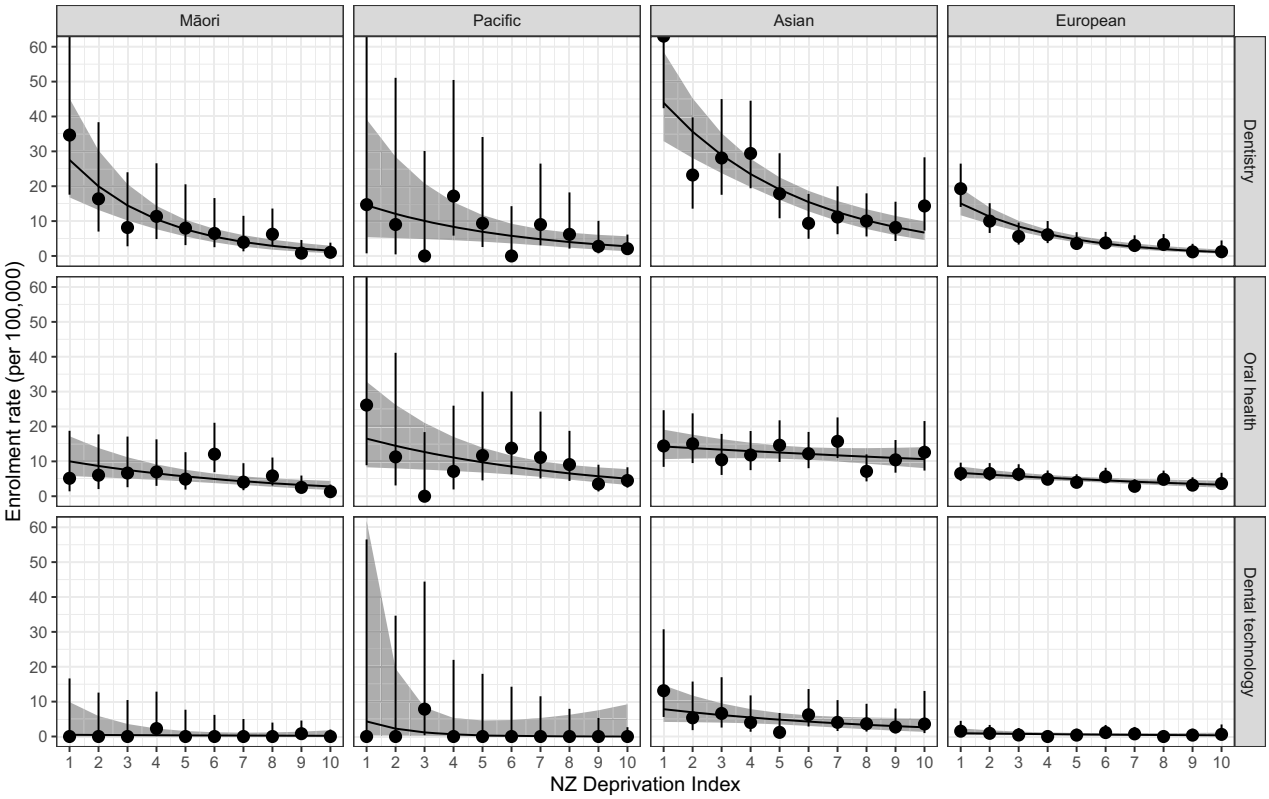

FIGURE 3 | Enrolment rates by ethnic groups and NZ Deprivation index (NZ citizens or permanent residents; 2016–2020 inclusive). Bachelor of Dental Surgery (Otago), Bachelor of Oral Health (Otago) and Bachelor of Health Science (Oral Health) (AUT) and Bachelor of Dental Technology (Otago). *Ethnicity: total response level 1. MELAA and Other were not included due to low numbers. Enrolment rate by NZDep2018 and ethnicity. Dots (vertical lines) represent observed rates (95% CI), and horizontal lines (grey shading) represent modelled rates (with 95% confidence intervals) treating NZDep2018 as a continuous variable.

professional programmes for Māori and students from other under-represented groups. Future studies are required to track improvements in student numbers from Māori and underrepresented groups and increased diversity in oral health students' cohorts.

The data reported here suggest a similar picture for remote and rural students where the number of enrolled students was not representative of rural communities. The oral health needs for remote and rural communities in NZ are significant, largely due to a lack of services in remote communities coupled with insufficient oral health education (Caldwell et al. 2017; Gaber et al. 2018). This pattern of inequity for rural populations has been observed for health outcomes more broadly for both Māori and non-Māori living in rural areas (Crengle et al. 2022; Nixon et al. 2023). Research suggests that the recruitment of students from rural communities into health professional programmes makes it more likely that students will return to those communities as health professionals (Nixon et al. 2019; Poole et al. 2021). Most BDS, OHT and BDentTech students attended higher decile schools (schools serving more socioeconomically privileged communities). However, the underrepresentation of students from low socioeconomic backgrounds is not unique to the oral health professions, as it has been observed in other health professions and other university courses in NZ (Crampton et al. 2023; Sise et al. 2024).

In keeping with all health professional programmes and indeed with university enrolment patterns overall, there were more females than males studying oral health programmes (Crampton et al. 2018; Crampton et al. 2023; Tran et al. 2024). The proportion of female students varied across programmes, with 63% of BDS, 91% of OHT and 76% of BDentTech students being female. These patterns would have been strongly influenced by historical gender patterns in the dental professions and associated pay differentials, which have resulted in 54% of the NZ BDS workforce being male (Dental Council 2022). With recent changes in student demographics and an ageing dental profession, it is expected that such changes will also be reflected in the profession's demographics, showing a more balanced gender distribution followed later by a predicted female-dominated dental workforce. In comparison, the predominantly female composition of OHT shows more needs to be done to attract and retain males into the profession. More OHT students are in older age ranges when compared to BDS and BDentTech students in this current study. This might be explained by dental assistants joining the OHT programmes or women wanting a career change after they have had children (Moffat and Coates 2011).

4.1 | Study Strengths and Limitations

The key strength of this study is that it included data for all students studying oral health programmes in NZ for the 5-year period of the study (2016–2020). The limitations of this retrospective, cross-sectional study include the fact that the analyses were restricted to data on students who were enrolled in oral health

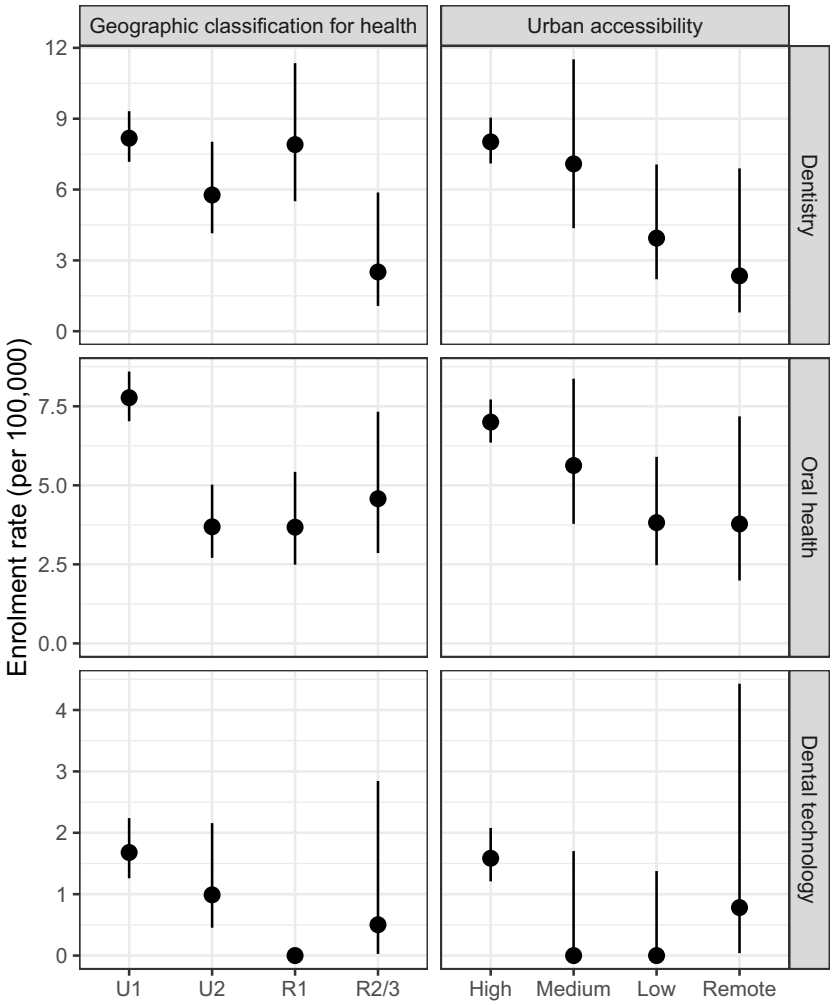

FIGURE 4 | Enrolment rates by geographic classification and urban accessibility (NZ citizens or permanent residents; 2016–2020 inclusive). Bachelor of Dental Surgery (Otago), Bachelor of Oral Health (Otago) and Bachelor of Health Science (Oral Health) (AUT) and Bachelor of Dental Technology (Otago). *Geographical area: Geographical Classification for Health (GCH) and urban accessibility (see Methods section for details); for GCH, the R2 and R3 categories are combined because of small numbers in the R3 category. Dots (lines) represent enrolment rate (95% CI) within each geographical area.

programmes. Evaluating the dynamic processes of offers, acceptances and withdrawals in health professional programme admissions was out of scope for this study, which focused only on the sociodemographic characteristics of students enrolled in the first year of study. Investigating the sociodemographic characteristics of students who are offered places but decline offers in oral health professional programmes could be analysed in future studies. Such studies could help elucidate the long-held assumption that many students decline an offer in dentistry due to a more desirable offer in medicine. However, the framing of student choice as a key issue fails to take a structural analysis of the power of institutions to address underrepresentation issues.

Because this study was carried out over a 5-year period, we are not able to report longer-term trends in enrolment patterns. Also, the data collected by universities was, for some variables, of suboptimal quality (e.g. the ethnicity data collection protocols used in some universities were not consistent with NZ's protocols for the health sector). Similarly, gender data collection was limited to the binary categories of male or female and therefore does not reflect gender diversity amongst students. In addition, because students in the 18–29-year-old age group tend to be mobile, their rural/urban status is not necessarily fixed. There may have been some error in the geographic analyses as the home addresses provided by students when they enrolled at university may not have reflected the rural/urban status of the community they grew up in.

Whilst it is essential that there is population parity for the recruitment of under-represented groups in oral health programmes, recruitment above population norms is necessary to compensate for years of low recruitment levels given the known benefits of having diverse cohorts in oral health professional programmes (Noonan and Evans 2003; Andersen et al. 2007). In addition, Māori rights to equitable health and oral health training access (and outcomes) further support urgent action. Central to success in this endeavour is the need to provide specific secondary and tertiary education interventions for oral health focused on Māori, Pacific, low socioeconomic, remote and rural student recruitment, bridging/foundation pathways, equity admission processes and comprehensive pastoral and academic support to these students once enrolled.

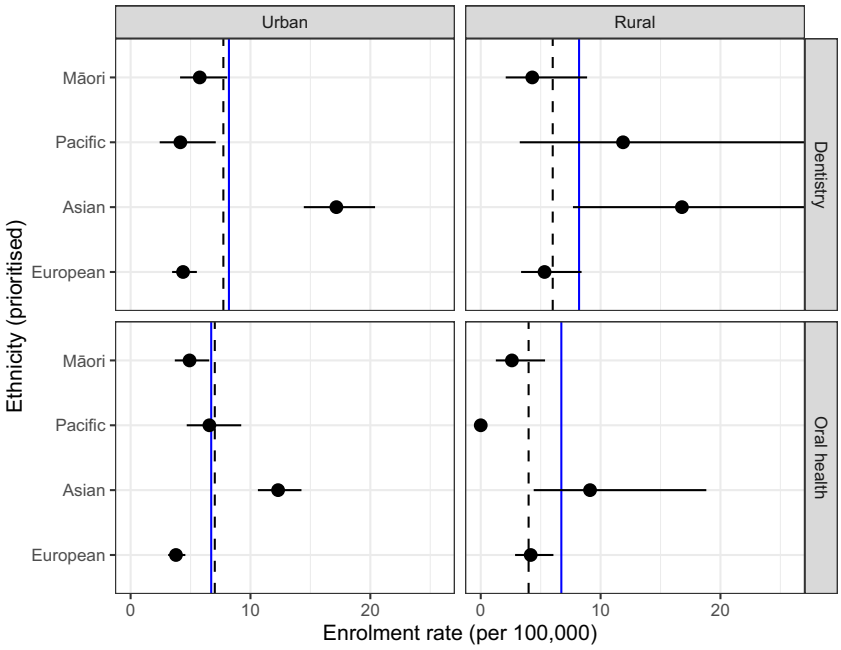

FIGURE 5 | Enrolment rates by ethnicity and urban/rural setting (NZ citizens or permanent residents; 2016–2020 inclusive). Bachelor of Dental Surgery (Otago) and Bachelor of Oral Health (Otago) and Bachelor of Health Science (Oral Health) (AUT). *Geographical area: Geographical Classification for Health (see Methods section for details). Ethnicity: prioritised. MELAA and Other categories were not included in this analysis. Solid blue line indicates overall enrolment rate, dashed line indicates enrolment rate for geographical area and dots (lines) represent enrolment rate (95% CI) for level 1 ethnic group within area.

5 | Conclusion

Data from this study show that Māori and Pacific peoples and those from rural and low socioeconomic areas were underrepresented in the 2016–2020 cohort of oral health professional students in NZ, despite efforts to address such inequities. Admission (intake) policies in NZ universities need ongoing review to ensure that Māori and Pacific peoples and those from rural and low socioeconomic areas are considered from a social justice and equity positioning for oral health professional programme entry. The NZ Government should also fund more domestic students to study the oral health professions, particularly the BDS programme, which has a cap of 60 funded places per year, and provide more resources and staff to support these students.

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Conflicts of Interest

One author of this study (P.C.) was involved in the development of the original 2012 admissions policy, and some of the authors (K.L., S.M., and J.A.) are involved in admission processes but were not involved in developing the admission/equity policies. The data presented here was based solely on student record databases.

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